NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Physical activity: encouraging activity in all people in contact with the NHS (staff, patients and carers)

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 03 June 2014

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for the topic of physical activity. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 Development source

The key development source(s) referenced in this briefing paper are:

- Physical activity: brief advice for adults in primary care. NICE public health guidance 44 (2013).
- Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation. NICE public heath guidance 41 (2012).
- Promoting physical activity for children and young people. NICE public health guidance 17 (2009).
- Promoting physical activity in the workplace. NICE public health guidance 13 (2008).
- Physical activity and the environment. NICE public health guidance 8 (2008).

2 Overview

2.1 Focus of quality standard

This quality standard will cover encouraging physical activity in all people who are in contact with the NHS, including staff, patients and carers. The quality standard will cover both children and adults.

2.2 Definition

Physical activity is 'any force exerted by skeletal muscle that results in energy expenditure above resting level'.[1]

Physical activity includes all forms of activity, such as everyday walking or cycling to get from one place to another, active play, work-related activity, active recreation (such as working out in a gym), dancing, gardening or playing active games, as well as organised and competitive sport.[2]

The Chief Medical Officers' (CMO) current recommendations for physical activity state that:

- All adults aged 19 years and over:-
    - should aim to be active daily.
    - Over a week, this should add up to at least 150 minutes (2.5 hours) of moderate intensity physical activity in bouts of 10 minutes or more.
    - Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity.
- All children and young people[3]:-
    - should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.
    - Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week. [4]

Moderate-intensity physical activity leads to faster breathing, increased heart rate and feeling warmer. Examples of moderate-intensity physical activity could include brisk walking, housework and domestic chores.

Vigorous-intensity physical activity leads to rapid breathing, shortness of breath, substantial increase in heart rate and should leave a person unable to maintain a

[1] Caspersen CJ, Powell KE, Christensen G (1985) Physical activity, exercise and physical fitness: definitions and distinctions of health-related research. Public Health Reports 100: 126–131.
[2] Department of Health (2011) Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers.
[3] Relates to children and young people aged 5-18 years. See the UK physical activity guidelines for guidance relating to children aged under 5 years.
[4] Department of Health (2011) UK physical activity guidelines.

conversation comfortably. Examples of vigorous-intensity activity could include running and climbing briskly up a hill.[5]

2.3 Incidence and prevalence

Physical inactivity is the fourth leading risk factor for global mortality (accounting for 6% of deaths globally). Despite the multiple health gains associated with a physically active lifestyle, there are high levels of inactivity across the UK.[6]

Inactivity costs the NHS an estimated £1.06 billion based on national cases of coronary heart disease, stroke, diabetes, colorectal cancer and breast cancer (all conditions that are potentially preventable or manageable through physical activity). This is a conservative estimate, given that there are a number of other health problems that physical activity can help manage and prevent.[7]

There are clear and significant health inequalities in relation to physical inactivity according to income, gender, age, ethnicity and disability. People tend to be less physically active as they get older and levels of physical activity are generally lower among women than men. Physical activity levels are also lower among certain minority ethnic groups, among people from lower socioeconomic groups and among people with disabilities.[8]

The Health Survey for England 2012[9] found that, based on self-reporting, 67% of men and 55% of women aged 16 and over met the CMO recommendations for physical activity. The survey also found that 26% of women and 19% of men were classed as inactive.

Figure 1 breaks down the results of the survey by age and sex showing which age groups had the highest proportion of men and women meeting the CMO recommendations.

[5] Department of Health (2011) Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers.
[6] Department of Health (2011) Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers.
[7] Allender S et al. (2007) The burden of physical activity-related ill health in the UK. Journal of Epidemiology and Community Health 61: 344–348.
[8] Department of Health (2011) Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers.
[9] Health & Social Care Information Centre (2014) Health Survey for England – 2012. Chapter 2 Physical activity in adults.

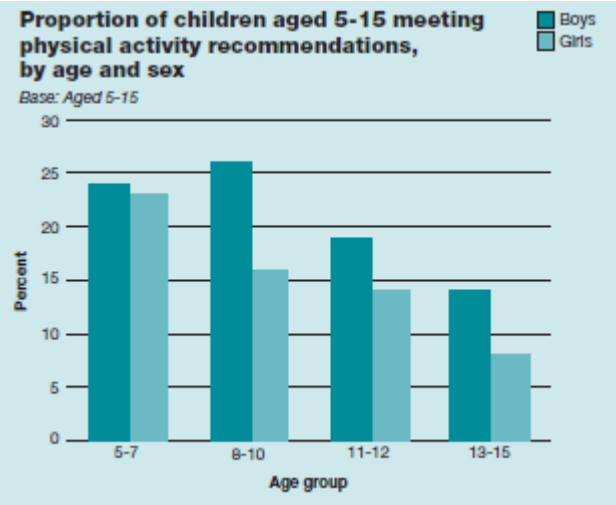
Figure 1 Summary activity levels, by age and sex

The previous recommendation for physical activity levels stated that adults aged 16 and over should achieve at least 30 minutes activity per day of at least moderate intensity, on at least five days per week. The proportion of adults meeting the previous recommendation has increased steadily since 1997 for men and 1998 for women. In 1997, 32% of men met the recommendation, increasing to 43% in 2012. Among women, 21% met the recommendation in 1997 and 1998, increasing to 32% in 2012. In both sexes, the proportion meeting the recommendation was similar in 2008 and 2012.

For children The Health Survey for England 2012 found that, based on self-reporting, a higher proportion of boys than girls aged 5-15 years (21% and 16% respectively[10]) met the CMO recommendations for physical activity for children and young people. Among both sexes, the proportion meeting the recommendations was lower in older children. Figure 2 shows the percentage of children meeting the recommendations broken down by age group and sex. For boys and girls aged 2-4 a similar proportion (9% and 10% respectively) were classified as meeting the CMO recommendations for physical activity. 84% of children of this age were classified in the 'low activity' group, meaning that they did less than an hour of activity a day, or did not do sufficient activity each day.

[10] Health & Social Care Information Centre (2014) Health Survey for England – 2012. Chapter 3 Physical activity in children.

Figure 2 Summary activity levels in children aged 5-15, by age and sex



For boys, there was a significant decrease over time in the proportion meeting current guidelines, falling from 28% in 2008 to 21% in 2012. The corresponding change among girls was not significant, falling from 19% to 16%. The decrease in the proportion meeting recommendations was more marked in the oldest age group: 28% of boys and 14% of girls aged 13-15 met the guidelines in 2008, compared with 14% and 8% respectively in 2012.

The Active People Survey (APS) measures sport participation amongst adults (aged 16 and over). The main measure is based on the percentage of adults playing at least 30 minutes of sport at moderate intensity at least once a week. A key finding from the latest APS[11] (April 2012 to April 2013) is that 15.5 million adults (35.7%) played sport for at least 30 minutes at moderate intensity at least once a week. This represents a 1.5 million increase on 2005/06.

2.4 Management

Encouraging physical activity in all people in contact with the NHS is important in helping to increase physical activity levels across the nation. In order to effectively encourage people to increase their physical activity it is important to be aware of effective behaviour change techniques. For an individual to improve their health in the medium and long term, behaviour change must be sustained. Maintaining changes to behaviour can involve both helping people to deal with relapses, and ensuring that new behaviours become habitual.[12]

The best way to encourage children and young people to be physically active may differ according to their age, developmental stage, culture and gender. For example, improving their physical skills and general ability to participate may make physical

[11] Sport England (2013) Active People Survey.
[12] Behaviour change: individual approaches. NICE public health guidance 49 (2014).

activity more enjoyable. It may also help increase their activity levels throughout childhood and into adulthood.[13]

Increasing physical activity has the potential to improve physical and mental health, reduce all-cause mortality and improve life expectancy. It can also have a positive impact on health and social care services by significantly easing the burden of chronic disease.[14] Physical activity helps to prevent and manage a number of conditions and also has a positive effect on wellbeing, mood, sense of achievement, relaxation and release from daily stress.[15]

Reducing sedentary behaviour is also important as evidence suggests a growing concern over the risks of sedentary behaviour. Some research has suggested that sedentary behaviour is independently associated with all-cause mortality, type 2 diabetes, some types of cancer and metabolic dysfunction.[16]

2.5 National Outcome Frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 The Adult Social Care Outcomes Framework 2014–15

Domain	Overarching and outcome measures
2 Delaying and reducing the need for care and support	***Overarching measure*** 2A Permanent admissions to residential and nursing care homes per 1000 population ***Outcome measures*** **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.** **Earlier diagnosis, intervention and re-ablement mean that people and their carers are less dependent on intensive services.** 2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services**
Aligning across the health and care system ** Indicator shared	

[13] Promoting physical activity for children and young people. NICE public health guidance 17 (2009).
[14] Department of Health (2011) Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers.
[15] Physical activity: brief advice for adults in primary care. NICE public health guidance 44 (2013).
[16] Sedentary Behaviour and Obesity Expert Working Group (2010) Sedentary Behaviour and Obesity: Review of the Current Scientific Evidence.

Table 2 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicator*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people 1b Life expectancy at 75 i Males ii Females ***Improvement areas*** Reducing premature mortality from the major causes of death 1.1 Under 75 mortality rate from cardiovascular disease* 1.2 Under 75 mortality rate from respiratory disease* 1.4 Under 75 mortality rate from cancer* i One- and ii Five-year survival from all cancers
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition** **Reducing time spent in hospital by people with long-term conditions** 2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s **Enhancing quality of life for people with dementia** 2.6 i Estimated diagnosis rate for people with dementia*
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicator*** 3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11*) ***Improvement areas*** **Improving recovery from stroke** 3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months **Helping older people to recover their independence after illness or injury** 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service*
Alignment across the health and social care system * Indicator shared with Public Health Outcomes Framework (PHOF) ** Indicator complementary with Adult Social Care Outcomes Framework (ASCOF)	

Table 3 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors which affect health and wellbeing and health inequalities ***Indicators*** 1.9 Sickness absence rate 1.16 Utilisation of outdoor space for exercise / health reasons 1.18 Social isolation
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.5 Child development at 2 – 2 ½ years 2.6 Excess weight in 4-5 and 10-11 year olds 2.8 Emotional well-being of looked after children 2.12 Excess weight in adults 2.13 Proportion of physically active and inactive adults 2.17 Recorded diabetes 2.23 Self-reported well-being 2.24 Injuries due to falls in people aged 65 and over
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities ***Indicators*** 4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* 4.5 Under 75 mortality rate from cancer* 4.7 Under 75 mortality rate from respiratory diseases* 4.11 Emergency readmissions within 30 days of discharge from hospital* 4.13 Health-related quality of life for older people (Placeholder) 4.14 Hip fractures in people aged 65 and over 4.16 Estimated diagnosis rate for people with dementia *

3 Summary of suggestions

3.1 Responses

In total 8 stakeholders responded to the 2-week engagement exercise 01/04/14–15/04/14. Three stakeholders advised that they had no comments to make at this stage of the development of the quality standard.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

Full details on the suggestions provided are given in appendix 1 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Organisational strategy • Physical activity strategy for NHS staff • Clinical commissioning group physical activity coordinator	RCP
Promoting active travel • Physical infrastructure of NHS sites • Soft measures for encouraging active travel in and around NHS sites	SCM
Prevention and management of clinical conditions • Brief interventions to facilitate the prevention and management of clinical conditions • GP referrals for physical activity • Medical royal colleges dissemination of information	MCS, SCM, RCP
Lifestyles and behaviours • Promotion of activities that can be embedded into everyday routines • Promoting good exercise habits from a young age	RDSH, SCM
Training and competency • Formal teaching of the health benefits of physical activity.	RCP
MCS, Macmillan Cancer Support RDSH, Rotherham Doncaster & South Humber NHS Trust RCP, Royal College of Physicians SCM, Specialist Committee Member	

4 Suggested improvement areas

4.1 Organisational strategy

4.1.1 Summary of suggestions

Physical activity strategy for NHS staff

Stakeholders highlighted the importance of each NHS organisation, including trusts and CCGs, having a clear physical activity strategy to promote regular physical activity for their staff. Stakeholders suggested that there should be a physical activity lead who is responsible for the strategy.

Clinical commissioning group (CCG) physical activity coordinator

Stakeholders suggested that each CCG should have a physical activity coordinator who is responsible for ensuring that each General Practice is keeping data on the physical activity levels of their patients. Stakeholders suggested that the physical activity coordinator should be responsible for developing a physical activity strategy to enable patients to receive advice on performing regular exercise.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. The relevant components of the public health guideline recommendations are presented after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Physical activity strategy for NHS staff	NICE PH13 Recommendation 1
CCG physical activity coordinator	Not covered in NICE guidance and no recommendations are presented.

Physical activity strategy for NHS staff

NICE PH13 – Recommendation 1(Policy and planning)

Develop an organisation-wide plan or policy to encourage and support employees to be more physically active. This should:

- include measures to maximise the opportunity for all employees to participate
- be based on consultation with staff and should ensure they are involved in planning and design, as well as monitoring activities, on an ongoing basis
- be supported by management and have dedicated resources
- set organisational goals and be linked to other relevant internal policies (for example, on alcohol, smoking, occupational health and safety, flexible working or travel)
- link to relevant national and local policies (for example, on health or transport).

4.1.3 Current UK practice

Physical activity strategy for NHS staff

The Royal College of Physicians (2014) report[17] presents findings from the Staff health improvement project, which assessed how NHS trusts have successfully implemented the NICE public health guidance for the workplace. The findings are based on an organisational audit conducted by the Health and Work Development Unit. The audit is based on six pieces of guidance for the workplace published by NICE. A simple scoring system was used to measure the extent of the implementation of NICE guidance and the audit uses self-reported data.

The 2014 document reports on round two data collected in 2013 and compares results with round one data collected in 2010. The total headcount of staff in all 178 trusts participating in round two was reported as 862,365. This represents 73% of all NHS staff in England. Relevant findings include the following:

- Only 44% (79/178) of trusts have a policy or plan for physical activity. This increased from 24% (41/172) in round one.

- Fewer than half of trusts monitor uptake of programmes to encourage physical activity by any inequality characteristics (e.g. age, gender, ethnicity).

- Of the 79 (44%) trusts with a physical activity plan, 63% (50/79) had been signed off by the board and 84% (66/79) had involved staff in its production.

[17] Royal College of Physicians (2014) Implementing NICE public health guidance for the workplace: an national organisational audit of NHS trusts in England Round 2.

- 87% (154/178) of trusts offer reduced membership to local leisure centres, 92% (164/178) a bike purchase scheme and 70% (125/178) on-site fitness classes.

The audit data demonstrates an increasing offer of opportunities to increase physical activity. However, it is not known whether this simply represents good intention or whether it is converted into increased uptake.

4.2 Promoting active travel

4.2.1 Summary of suggestions

Physical infrastructure of NHS sites

Stakeholders highlighted the importance of ensuring that the physical infrastructure at NHS sites facilitates active travel, such as walking and cycling, for staff, patients and visitors.

Soft measures for encouraging active travel in and around NHS sites

Stakeholders highlighted the importance of using 'soft measures' to promote active travel to, from and within NHS sites such as: having an 'active travel champion'; having effective travel plans and management of travel demand; and undertaking promotional activities to encourage active travel in and around NHS sites.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. The relevant components of the public health guideline recommendations are presented after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Physical infrastructure of NHS sites	NICE PH8 Recommendations 1, 5 and 6. NICE PH41 Recommendations 5, 6 and 9.
Soft measures for encouraging active travel in and around NHS sites	NICE PH13 Recommendations 1, 2 and 3. NICE PH41 Recommendation 9.

Physical infrastructure of NHS sites

<u>NICE PH8 Recommendation 1(Strategies, policies and plans)</u>

- Involve all local communities and experts at all stages of the development to ensure the potential for physical activity is maximised.
- Ensure planning applications for new developments always prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life. Ensure local facilities and services are easily accessible on foot, by bicycle and by other modes of transport involving physical activity. Ensure children can participate in physically active play.

- Assess in advance what impact (both intended and unintended) the proposals are likely to have on physical activity levels. (For example, will local services be accessible on foot, by bicycle or by people whose mobility is impaired?) Make the results publicly available and accessible. Existing impact assessment tools could be used.

NICE PH8 Recommendation 5 (Buildings)

- Those involved with campus sites, including hospitals and universities, should ensure different parts of the site are linked by appropriate walking and cycling routes. (Campuses comprise two or more related buildings set together in the grounds of a defined site.)
- Ensure new workplaces are linked to walking and cycling networks. Where possible, these links should improve the existing walking and cycling infrastructure by creating new, through routes (and not just links to the new facility).

NICE PH8 Recommendation 6 (Buildings)

- During building design or refurbishment, ensure staircases are designed and positioned to encourage people to use them.
- Ensure staircases are clearly signposted and are attractive to use. For example, they should be well-lit and well-decorated.

NICE PH41 Recommendation 5 (Cycling programmes)

- Address infrastructure and planning issues that may discourage people from wanting to cycle. Take into account NICE's recommendations on physical activity and the environment and on road design. For example, ensure local facilities and services are easily accessible by bicycle and make changes to existing roads, where necessary, to reduce traffic speeds.

NICE PH41 Recommendation 6 (Walking: community-wide programmes)

- Address infrastructure issues that may discourage people from walking, for example, motor traffic volume and speed, lack of convenient road crossings, poorly maintained footways or lack of dropped kerbs, where needed. Take into account NICE's recommendations on physical activity and the environment and on road design.

NICE PH41 Recommendation 9 (Workplaces)

- Liaise with local authority transport departments, neighbouring businesses and other partners to improve walking and cycling access to workplace sites. (Also see NICE's recommendations on physical activity and the environment and promoting physical activity in the workplace.)

Soft measures for encouraging active travel in and around NHS sites

NICE PH13 Recommendation 1 (Policy and planning)

Develop an organisation-wide plan or policy to encourage and support employees to be more physically active. This should:

- include measures to maximise the opportunity for all employees to participate
- be based on consultation with staff and should ensure they are involved in planning and design, as well as monitoring activities, on an ongoing basis
- be supported by management and have dedicated resources
- set organisational goals and be linked to other relevant internal policies (for example, on alcohol, smoking, occupational health and safety, flexible working or travel)
- link to relevant national and local policies (for example, on health or transport).

NICE PH13 Recommendation 2 (Implementing a physical activity programme)

Introduce and monitor an organisation-wide, multi-component programme to encourage and support employees to be physically active. This could be part of a broader programme to improve health. It could include:

- flexible working policies and incentive schemes
- policies to encourage employees to walk, cycle or use other modes of transport involving physical activity (to travel to and from work and as part of their working day)
- the dissemination of information (including written information) on how to be more physically active and on the health benefits of such activity. This could include information on local opportunities to be physically active (both within and outside the workplace) tailored to meet specific needs, for example, the needs of shift workers
- ongoing advice and support to help people plan how they are going to increase their levels of physical activity
- the offer of a confidential, independent health check administered by a suitably qualified practitioner and focused on physical activity.

NICE PH13 Recommendation 3 (Components of the physical activity programme)

- Encourage employees to walk, cycle or use another mode of transport involving physical activity to travel part or all of the way to and from work (for example, by developing a travel plan).
- Help employees to be physically active during the working day by:
    - where possible, encouraging them to move around more at work (for example, by walking to external meetings)

- putting up signs at strategic points and distributing written information to encourage them to use the stairs rather than lifts if they can
- providing information about walking and cycling routes and encouraging them to take short walks during work breaks
- encouraging them to set goals on how far they walk and cycle and to monitor the distances they cover.

NICE PH41 Recommendation 9 (Workplaces)

- Identify an 'active travel champion' (or champions) within the workplace, at a sufficiently senior level. They should coordinate activities such as led and informal walking groups, workplace 'challenges' and promotional competitions (for example, using pedometers), bicycle user groups and walking interest groups. The active travel champion/s should also develop (or promote) schemes that give staff access to a pool of bicycles for short-distance business travel, or access to discounted cycle purchases (such as cycle to work schemes).
- Ensure workplace walking and cycling programmes are developed using an evidence-based theoretical model of behaviour change (see NICE guidance on Behaviour change: the principles for effective interventions).
- Provide information tailored for the specific workplace on walking and cycling routes and circuits. This should include details on the distances involved, maps, routes and safety information.

4.2.3 Current UK practice

Physical infrastructure of NHS sites

The Royal College of Physicians (2014) report[18] presents findings from the Staff health improvement project, which assessed how NHS trusts have successfully implemented the NICE public health guidance for the workplace. The findings are based on an organisational audit conducted by the Health and Work Development Unit. The audit is based on six pieces of guidance for the workplace published by NICE. A simple scoring system was used to measure the extent of the implementation of NICE guidance and the audit uses self-reported data.

The 2014 document reports on round two data collected in 2013 and compares results with round one data collected in 2010. The total headcount of staff in all 178 trusts participating in round two was reported as 862,365. This represents 73% of all NHS staff in England. Relevant findings include the following:

[18] Royal College of Physicians (2014) Implementing NICE public health guidance for the workplace: an national organisational audit of NHS trusts in England Round 2.

- Nearly all trusts (94% in round one and round two) provided safe and secure cycle parking.
- When trusts were asked about staircases only 35% (compared with 26% in round one) confirmed that all staircases were clearly signposted and attractive to use (e.g. well-lit and well-decorated).
- When trusts were asked if all parts of a campus site were linked by appropriate walking and cycling routes the results were as follows: 52% answered yes, 11% answered no and 37% said not applicable.

Soft measures for encouraging active travel in and around NHS sites

The Royal College of Physicians (2014) report[19] presents findings from the Staff health improvement project, which assessed how NHS trusts have successfully implemented the NICE public health guidance for the workplace. Relevant findings include the following:

- 80% (143/178) of trusts have an active travel plan to encourage and enable staff to walk or cycle to work and between sites.
- 92% of trusts offer (164/178) a bike purchase scheme.

[19] Royal College of Physicians (2014) Implementing NICE public health guidance for the workplace: an national organisational audit of NHS trusts in England Round 2.

4.3 Prevention and management of clinical conditions

4.3.1 Summary of suggestions

Brief interventions to facilitate the prevention and management of clinical conditions

Stakeholders raised the importance of brief interventions, including motivational interviewing, to enable people to become and stay more active. It was suggested that this needs to be integrated into all relevant clinical pathways in order to facilitate the primary prevention and management of all clinical conditions where physical activity is a modifiable risk factor. Stakeholders also suggested that all healthcare professionals should use every contact they have with individuals as an opportunity to help people maintain and improve their mental and physical health and wellbeing by targeting lifestyle risk factors such as physical activity.

GP referrals for physical activity

Stakeholders suggested that GP consultations with patients are an opportunity for teaching people about physical activity and that referrals for exercise can be an appropriate alternative to medication for some people.

Medical royal colleges dissemination of information

Stakeholders suggested that each of the medical royal colleges should have strategies in place for disseminating information to their members on the health benefits of exercise and how this relates to each specialty.

4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. The relevant components of the public health guideline recommendations are presented after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Brief interventions to facilitate the prevention and management of clinical conditions	NICE PH44 Recommendations 1, 2 and 3. NICE PH41 Recommendations 1 and 10. NICE PH17 Recommendation 15.
GP referrals for physical activity	NICE PH44 Recommendation 1.

Medical royal colleges dissemination of information	Not covered in NICE guidance and no recommendations are presented.

Brief interventions to facilitate the prevention and management of clinical conditions

NICE PH44 Recommendation 1 (Identifying adults who are inactive)

- Identify adults who are not currently meeting the UK physical activity guidelines (see box 1). This could be done, for example:
    - when the opportunity arises during a consultation with a primary care practitioner or while people are waiting
    - as part of a planned session on management of long-term conditions.
- Use professional judgement to determine when this assessment would be most appropriate, for example, when someone is presenting with a condition that could be alleviated by physical activity. When assessing activity levels, remain sensitive to people's overall circumstances. If it is not appropriate during the current consultation, carry out an assessment at the next available opportunity.
- Do not rely on visual cues (for example, body weight). Use validated tools such as GPPAQ[1] to assess physical activity levels.
- For people who are not meeting the UK guidelines, identify the most appropriate time to discuss physical activity with them. This might be during the current consultation or in a later consultation, and might involve referral to another member of the primary care team. If they agree to a future consultation, make sure it occurs at the earliest opportunity. Ensure the person at least leaves the initial consultation aware of the health benefits of physical activity (see box 2).
- Record the outcomes of the physical activity assessment. Use Read Codes if appropriate.
- Encourage people who are assessed as meeting the UK physical activity guidelines (see box 1) to maintain this level of activity.

NICE PH44 Recommendation 2 (Delivering and following up on brief advice)

- Advise adults who have been assessed as being inactive to do more physical activity, with the aim of achieving the UK physical activity guidelines. Emphasise the benefits of physical activity. (See box 1.)
- When delivering brief advice, tailor it to the person's:
    - motivations and goals (see NICE guidance on Behaviour change: the principles for effective interventions [public health guidance 6])
    - current level of activity and ability

    - circumstances, preferences and barriers to being physically active
    - health status (for example whether they have a medical condition or a disability).

- Provide information about local opportunities to be physically active for people with a range of abilities, preferences and needs.
- Consider giving a written outline of the advice and goals that have been discussed.
- Record the outcomes of the discussion.
- Follow up when there is another appointment or opportunity. The follow-up could consist of a conversation about what physical activity someone has been doing, progress towards their goals or towards achieving the UK physical activity guidelines (see box 1).

NICE PH44 Recommendation 3 (Incorporating brief advice in commissioning)

- When commissioning services to prevent or treat conditions such as cardiovascular disease, type 2 diabetes and stroke or to improve mental health, ensure brief advice on physical activity is incorporated into the care pathway.

NICE PH41 Recommendation 1 (High-level support from the health sector)

- Ensure walking and cycling are considered, alongside other interventions, when working to achieve specific health outcomes in relation to the local population (such as a reduction in the risk of cardiovascular disease, cancer, obesity and diabetes, or the promotion of mental wellbeing[20]). These include outcomes identified through the joint strategic needs assessment process.
- Ensure walking and cycling are included in chronic disease pathways.

NICE PH41 Recommendation 10 (NHS)

- Incorporate information on walking and cycling into all physical activity advice given by health professionals. (See also NICE's recommendations on four commonly used methods to increase physical activity.)
- Ensure walking and cycling are among the options provided by the Let's get moving physical activity care pathway.
- Ensure people who express an interest in walking or cycling as a way of being more physically active are given information about appropriate national and local initiatives. Also provide individual support and follow-up (see recommendation 7).
- Direct people with limited mobility to specialist centres where adapted equipment, assessment and training are available for walking and cycling.

[20] Descriptions of the links between physical activity and health outcomes can be found in the Chief Medical Officers' report on physical activity Start active, stay active.

NICE PH17 Recommendation 15 (Helping families to be active)

- Ensure parents and carers are aware of government advice that children and young people should undertake a minimum of 60 minutes moderate to vigorous physical activity a day. Make them aware that, at least twice a week, this should include activities to improve bone health, muscle strength and flexibility.
- Provide information and advice on the benefits of physical activity, emphasising how enjoyable it is. Provide examples of local opportunities.
- Encourage parents and carers to get involved in physical activities with their children.
- Encourage parents and carers to complete at least some local journeys (or some part of a local journey) with young children using a physically active mode of travel. This should take place on most days of the week. The aim is to establish physically active travel (such as walking or cycling) as a life-long habit from an early age. Parents and carers should also be encouraged to allow their children to become more independent, by gradually allowing them to walk, cycle or use another physically active mode of travel for short distances.
- Act as a role model by incorporating physical activity into daily life. For example, opt for travel involving physical activity (such as walking or cycling), use the stairs and regularly participate in recreational activities or sport.
- Promote physically active travel as an option for all the family. Raise awareness of how it can help children and young people achieve the recommended daily amount of physical activity.

GP referrals for physical activity

NICE PH44 Recommendation 1 (Identifying adults who are inactive)

- Identify adults who are not currently meeting the UK physical activity guidelines (see box 1). This could be done, for example:
    - when the opportunity arises during a consultation with a primary care practitioner or while people are waiting
    - as part of a planned session on management of long-term conditions.
- Use professional judgement to determine when this assessment would be most appropriate, for example, when someone is presenting with a condition that could be alleviated by physical activity. When assessing activity levels, remain sensitive to people's overall circumstances. If it is not appropriate during the current consultation, carry out an assessment at the next available opportunity.
- Do not rely on visual cues (for example, body weight). Use validated tools such as GPPAQ[1] to assess physical activity levels.

- For people who are not meeting the UK guidelines, identify the most appropriate time to discuss physical activity with them. This might be during the current consultation or in a later consultation, and might involve referral to another member of the primary care team. If they agree to a future consultation, make sure it occurs at the earliest opportunity. Ensure the person at least leaves the initial consultation aware of the health benefits of physical activity (see box 2).
- Record the outcomes of the physical activity assessment. Use Read Codes if appropriate.
- Encourage people who are assessed as meeting the UK physical activity guidelines (see box 1) to maintain this level of activity.

4.3.3 Current UK practice

Brief interventions to facilitate the prevention and management of clinical conditions

In a report on the Joint Strategic Needs Assessment for Berkshire West 2010/11, key issues around physical activity are discussed, and recommendations made for commissioners. The report highlights that almost 80% of people in the area saw their GP at least once in 2010/11 but less than half of them received any advice on diet and exercise.[21]

Goodman et al[22] (2011) undertook research to discover the current level of nurse-led involvement in activity promotion for older people in primary care and to explore the knowledge and attitudes of primary care nurses about health benefits of activity promotion for older people. This study surveyed all nurses and health visitors working in five primary care organisations in an inner city area. A semi-structured postal questionnaire asked about their knowledge and attitudes to the benefits of exercise in later life, their current levels of involvement in promoting physical activity with older people, and their personal activity levels. The overall response rate was 54% (391 district nurses and practice nurses).

Nurses had the commitment and (depending on the focus of their work) different opportunities to promote physical activity with older patients. There were organisational and individual constraints on their ability to be involved in this aspect of health promotion work themselves, or to refer older people to local activity promotion schemes. Nurses did not have a structured approach when promoting physical activity with older people and had only a partial awareness of the limitations of their knowledge or skills when promoting activity with older people. Conclusions were that for promotion of physical activity to be meaningfully incorporated into

[21] Reading Borough Council, NHS Berkshire West, West Berkshire Council & Wokingham Borough Council (2011) Joint strategic needs assessment for Berkshire West 2010/11 Wellbeing and prevention physical activity.
[22] Goodman et al. (2011) Activity promotion for community-dwelling older people: a survey of the contribution of primary care nurses. British Journal of Community Nursing Vol 16:1: 12-17.

primary care nursing work there is a need to develop a more strategic approach that can optimise the opportunities and interest of primary care nurses and develop the knowledge and skills of the workforce in this area of nursing work.

GP referrals for physical activity

The British Heart Foundation National Centre for Physical Activity and Health (BHFNC) (2010) Exercise Referral Toolkit 2010[23] provides information on exercise referral schemes. A mapping exercise was undertaken to identify and survey existing exercise referral schemes in England, Scotland and Northern Ireland to ascertain the nature and extent of current practice. Questionnaires were sent to 198 named exercise referral professionals working in various regions. One-hundred and fifty-eight questionnaires were received for England and Scotland. Two-hundred and two questionnaires were received from GPs and forty-three questionnaires were returned by leisure centre managers in Northern Ireland.

There are some areas in England, Scotland and Northern Ireland which are not covered by schemes; however this may reflect a non-response rather than a lack of provision.

The lead agencies responsible for schemes were in the public sector; the majority (75%) of schemes were developed and coordinated either by the PCT/NHS Health Board, the local authority or as a joint venture between local authorities and PCTs/NHS Health Boards.

The majority of schemes in England and Scotland (69%) were fairly well established and had been operating for at least 4 years. In Northern Ireland schemes were slightly younger; the majority of schemes (72%) had been running for 4 years or less.

The overall aim of the majority of schemes was to improve the health and wellbeing of the local population by promoting and providing opportunities for increased physical activity.

[23] BHF National Centre for Physical Activity and Health (2010) Exercise Referral Toolkit 2010.

4.4 Lifestyles and behaviours

4.4.1 Summary of suggestions

Promotion of activities that can be embedded into everyday routines

Stakeholders highlighted the potential gains of developing habitual active behaviour, for example walking or cycling to work, over more structured fitness sessions.

Promoting good exercise habits from a young age

Stakeholders highlighted the importance of instilling healthy eating and good exercise habits from a young age in order to help prevent people from becoming obese and developing other conditions linked to lifestyle choices and behaviours. Stakeholders also raised the specific issue of promoting active travel to parents and carers via home visitors, school nurses and other professionals in contact with families.

4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. The relevant components of the public health guideline recommendations are presented after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Promotion of activities that can be embedded into everyday routines	NICE PH41 Recommendation 10. NICE PH17 Recommendation 15.
Promoting good exercise habits from a young age	NICE PH41 Recommendation 10. NICE PH17 Recommendation 15.

Promotion of activities that can be embedded into everyday routines

NICE PH41 Recommendation 10 (NHS)

- Incorporate information on walking and cycling into all physical activity advice given by health professionals. (See also NICE's recommendations on four commonly used methods to increase physical activity.)

NICE PH17 Recommendation 15 (Helping families to be active)

- Encourage parents and carers to complete at least some local journeys (or some part of a local journey) with young children using a physically active mode of travel. This should take place on most days of the week. The aim is to establish physically active travel (such as walking or cycling) as a life-long habit from an early age. Parents and carers should also be encouraged to allow their children to become more independent, by gradually allowing them to walk, cycle or use another physically active mode of travel for short distances.
- Promote physically active travel as an option for all the family. Raise awareness of how it can help children and young people achieve the recommended daily amount of physical activity.

Promoting good exercise habits from a young age

NICE PH41 Recommendation 10 (NHS)

- Incorporate information on walking and cycling into all physical activity advice given by health professionals. (See also NICE's recommendations on four commonly used methods to increase physical activity.)
- Ensure walking and cycling are among the options provided by the Let's get moving physical activity care pathway.
- Ensure people who express an interest in walking or cycling as a way of being more physically active are given information about appropriate national and local initiatives. Also provide individual support and follow-up (see recommendation 7).

NICE PH17 Recommendation 15 (Helping families to be active)

- Ensure parents and carers are aware of government advice that children and young people should undertake a minimum of 60 minutes moderate to vigorous physical activity a day. Make them aware that, at least twice a week, this should include activities to improve bone health, muscle strength and flexibility.
- Provide information and advice on the benefits of physical activity, emphasising how enjoyable it is. Provide examples of local opportunities.
- Encourage parents and carers to get involved in physical activities with their children.
- Encourage parents and carers to complete at least some local journeys (or some part of a local journey) with young children using a physically active mode of travel. This should take place on most days of the week. The aim is to establish physically active travel (such as walking or cycling) as a life-long habit from an early age. Parents and carers should also be encouraged to allow their children to become more independent, by gradually allowing them to walk, cycle or use another physically active mode of travel for short distances.

- Act as a role model by incorporating physical activity into daily life. For example, opt for travel involving physical activity (such as walking or cycling), use the stairs and regularly participate in recreational activities or sport.
- Promote physically active travel as an option for all the family. Raise awareness of how it can help children and young people achieve the recommended daily amount of physical activity.

4.4.3 Current UK practice

Promotion of activities that can be embedded into everyday routines

No published studies were found for this suggested area for improvement. The data presented below highlights some findings in relation to participation in activities that can be embedded into everyday routines.

The National Travel Survey[24] (NTS) (2012) reports on the frequency of travel by different modes of transport including walking and cycling.

Relevant findings include the following:

- In 2012, 64% of all trips were made by car (as a driver or a passenger), 22% were made by walking and 2% by bicycle.
- In 2012, the average number of walking trips was 212 trips per person per year compared with 292 trips in 1995/97 (a decrease of 27%).
- Cycling is most prevalent among men (23 trips person per year compared with 9 trips by women). However, cycling only makes up 2% and 1% respectively of their total trips.

The key findings from Local area walking and cycling: England 2011/12[25] include:

- During the year ending October 2012, 10% of adults in England cycled at least once per week and 3% of adults cycled at least 5 times per week. The prevalence of cycling in England has not changed significantly, compared to the same period for the previous year.
- Across different local authorities, the proportion of adults cycling at least once per week ranges from 47% to lower than 5% in other areas.
- According to the 2011 Census, around 2% of adults in England usually travel to work by bicycle.

[24] Department for Transport (2012) The National Travel Survey 2012.
[25] Department for Transport (2013) Local area walking and cycling: England 2011/12.

Promoting good exercise habits from a young age

No published studies were found for this suggested area for improvement. The data presented below highlights some findings in relation to the current exercise habits of children and young people.

The NTS[26] (2012) reported that:

- 47% of trips to and from school by primary school children (aged 5-10) were made on foot. This was lower than in 1995/97 when 53% of trips were made on foot.
- Among secondary school children (aged 11-16) in 2012, 38% of school trips were on foot and 26% were by car, compared with 42% and 20% respectively in 1995/97.
- For secondary school children, the proportion of trips by bicycle was 2%.
- For trips to school less than 1 mile in length, walking was the most prevalent mode of travel for both primary and secondary school children, accounting for 79% and 89% of trips respectively.

The HSE 2012[27] included questions on how children travel to and from school, playgroup or nursery.

- Around two thirds of both boys and girls aged 2-15 walked to or from school on at least one occasion in the last week (64% and 67% respectively).
- More boys than girls aged 2-15 (6% and 1% respectively) cycled to or from school on at least one day in the last week.

The survey also showed that among both boys and girls, the average amount of time spent per week in total physical activity decreased significantly between the two surveys in each age group. This decrease reflects falls in the amount of participation in informal/formal activities, while there was no significant change in the amount of time spent in active travel to or from school.

Participants were asked about sedentary time after school, and therefore any sedentary time during the school day is not included. Mean total sedentary time was similar for boys and girls on weekdays (3.3 hours and 3.2 hours respectively) and weekend days (4.2 hours and 4.0 hours respectively).

[26] Department for Transport (2012) The National Travel Survey 2012.
[27] Health & Social Care Information Centre (2014) Health Survey for England – 2012. Chapter 3 Physical activity in children.

Bentley et al (2012) found that the majority of interventions to increase physical activity in children are school-based and reviews highlight that many school-based interventions have had limited success.[28]

[28] Bentley GF et al. (2012) Parents' views on child physical activity and their implications for physical activity parenting interventions: a qualitative study. BMC Pediatrics 2012, 12:180.

4.5 Training and competency

4.5.1 Summary of suggestions

Formal teaching of the health benefits of physical activity

Stakeholders suggested that the health benefits of physical activity should be taught formally to all undergraduates studying medicine, nursing and physiotherapy.

4.5.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. The relevant components of the public health guideline recommendations are presented after table 9 to help inform the Committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations[29]
Formal teaching of the health benefits of physical activity	NICE PH44 Recommendation 5. NICE PH17 Recommendation 8.

Formal teaching of the health benefits of physical activity

NICE PH44 Recommendation 5 (Providing information and training)

Provide information and training for primary care practitioners. This should cover:

- how physical activity promotion fits within their remit and how it can help prevent and manage a range of health conditions (see box 2)
- the definition of physical activity: what constitutes moderate and vigorous physical activity, and what intensity, duration and frequency of physical activity is needed to achieve the UK physical activity guidelines (see box 1)
- groups more likely to be inactive (see recommendation 3)
- misconceptions about who needs to increase their physical activity (based, for example, on visual cues such as body weight)
- how to undertake physical activity assessments
- local opportunities for physical activity
- the needs of specific groups, such as people with disabilities, including local opportunities for them to be physically active

[29] Note: the recommendations presented do not relate to formal teaching but are about providing information and training to primary care practitioners.

- delivery of brief advice including, for example, the skills to motivate people to change (see NICE guidance on Behaviour change: the principles for effective interventions [public health guidance 6]).

NICE PH17 Recommendation 8 (Training and continuing professional development)

- Establish continuing professional development (CPD) programmes for people involved in organising and running formal and informal physical activities. The education and training should enable them to:
    - give children and young people information and advice on physical activity, taking into account their needs (for example, their developmental age, physical ability and any medical conditions they may have)
    - give children and young people confidence in their own abilities and motivate them to be physically active (this includes encouraging them to set goals, where appropriate)
    - understand the practical issues and problems that may discourage families or groups of children and young people from getting involved. (This may include, for example, time constraints, access issues – including accessibility for those with a disability – and the cultural appropriateness of activities)
    - develop and foster partnership working and get the local community involved.
- Monitor and evaluate the impact of training on practitioner performance.
- Train people to deliver physical activity CPD programmes.

4.5.3 Current UK practice

Dunlop[30] (2013) completed a study to assess UK medical students' knowledge of physical activity guidelines and their ability or willingness to prescribe exercise. A questionnaire survey of final year medical students in Scottish Universities was conducted prior to a presentation on the current UK guidelines. Completed questionnaires represented 37% of the final year cohorts. The findings of the study included the following:

[30] Dunlop M and Murray AD (2013) Major limitations in knowledge of physical activity guidelines among UK medical students revealed: implications for the undergraduate medical curriculum. British Journal of Sports Medicine 2013 47(11):718-20.

- Physical inactivity was incorrectly perceived to be the least important risk factor to global mortality.
- 40% stated they were aware of current guidelines, but in a forced choice, 68% were able to correctly identify them for adults.
- 52% stated they felt adequately trained to give physical activity advice to the general public.

Conclusions were that the medical students in this study underestimated the risk of physical inactivity, and did not know the physical activity guidelines as well as other health promotion guidelines. A large proportion remained unconfident about giving physical activity advice.

Weiler et al[31] (2012) undertook research with the aim of assessing the provision of physical activity teaching content in the curricula of all medical schools in the UK. A questionnaire was used to assess the content, form and timing of key aspects of education on physical activity promotion according to current national guidelines, within the 31 medical schools in the UK. A 100% response rate was achieved. Response rates for individual questions varied. Five medical schools (16% of responders) did not include any specific physical activity teaching within their curricula. Four medical schools (15% of responders) taught physical activity within all 5 years of the curricula. Only 15 (56% of responders and 87% responded) medical schools teach the current CMO guidance for PA. Delivery of physical activity teaching is varied across UK medical schools but overall, was sparse or non-existent. There is widespread omission of basic teaching elements, such as the CMO recommendations and guidance on physical activity, which has been endorsed by all four UK Departments of Health.

[31] Weiler,R et al. (2012) Physical activity education in the undergraduate curricula of all UK medical schools: are tomorrow's doctors equipped to follow clinical guidelines? British Journal of Sports Medicine. Nov 2012; 46(14): 1024–1026.

4.6 Additional areas

4.6.1 Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise however they were felt to be outside the remit of quality standards or are addressed by other NICE quality standard topics.

There will be an opportunity for the QSAC to discuss these areas at the end of the session.

Physical activity for people living with and beyond cancer

Stakeholders raised the issue that there is an increasing evidence base for the benefits of physical activity for people living with and beyond cancer.

Mental health

Stakeholders referred to the link between mental health and physical health highlighting the fact that having a mental health problem increases the risk of physical ill health.

Regulation of exercise professionals working at level 4

Stakeholders suggested that exercise professionals working at level 4 should be regulated by the Health Care Professions Council.

Appendix 1: Suggestions from stakeholder engagement exercise

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
001	NHS England	Dear NICE Thank you for the opportunity to comment the stakeholder engagement exercise for the above Quality Standard I wish to confirm that NHS England has no substantive comments to make regarding this consultation. Kind Regards Quality Framework Team NHS England			
002	SCM1	*Key area for quality improvement 1* 'Active travel' access to NHS by staff, patients and visitors as the norm, by improving **physical infrastructure** at NHS sites and linking NHS sites to places where people live	There is good evidence that 'active travel' modes (walking and cycling) alone or in conjunction with public transport are an effective way to build physical activity into people's lives, helping them to meet CMO guidance on levels of physical activity. Walking and cycling are low-cost modes of transport, ideal for relatively short trips	Continued low mode share of walking and cycling for short trips in England, and high proportion of short trips undertaken by private car, means that opportunity for many people to integrate physical activity into their daily routine is not taken up. Insufficiently high levels of physical activity amongst all age groups has a range of consequences for the NHS and wider society including effects on workforce health - and more generally on prevalence of non-communicable diseases. Current levels of car dependence have other associated costs, some of which have been quantified, under headings of collisions, traffic congestion; air pollution; carbon emissions; community severance;	DfT local area walking and cycling statistics for England and Wales, most recently published at https://www.gov.uk/government/publications/local-area-walking-and-cycling-in-england-2011-12 highlights low (and essentially static levels) of cycling across England e.g. this notes that, according to the 2011 Census, around 2% of adults in England usually travel to work by bicycle. There has been an overall decline in average distances walked since 1995/97, see Department for Transport National Travel Survey statistics, Table NTS0305 Average distance travelled by mode: Great Britain, 1995/97 to

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			and are widely available to people of all ages. Designing new NHS sites provides an opportunity to 'build in' active travel to that site's NHS services from the outset. Remodelling existing sites offers the chance to redress deficiencies in provision for active travel and similarly to minimise the site's transport and environmental impact on the surrounding community. NHS sites are major 'trip generators' with – taking London as an example – Transport for	high operating costs; and, in the context of NHS sites, pressure on NHS property (some NHS sites have high proportions of land given to car parking). There is widespread dissatisfaction within the sustainable transport campaigning community in the UK with cycling and walking infrastructure and the level of priority commonly given to cyclists and pedestrians in designing and maintaining physical infrastructure. Experience as a user of NHS sites is that commonly they (inadvertently) discourage or give mixed messages towards active travel. For example: sites with some good provision for pedestrians and cyclists but which are dominated by provision for motorised transport; poor quality walking and cycling routes to and within sites; cycle parking that is hidden and badly designed, installed and maintained. (Physical activity issues may extend to within buildings, with stairs sometimes hidden and even where visible with an unattractive environment, resulting in many	2012 https://www.gov.uk/government/statistical-data-sets/nts03-modal-comparisons See also: 'Improving the health of Londoners: transport action plan'. Transport for London, February 2014. p. 56 of this document refers to the authors' Health Service Travel Analysis Toolkit (HSTAT), also 'Transport Planning for Healthier Lifestyles' and 'Transport Planning for Health'.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			London's Health Action Plan estimating that around 5% of trips (1 million per day) in London are related to the healthcare sector. This report also notes that “Travel and accessibiity are of great importance to the public, patients and staff, particularly when changes to healthcare provision are being discussed.” (p. 56) Walking and cycling are highly sensitive to directness of journeys, and to safety and perceived safety of travel – thus directly linked to quality of physical infrastructure available.	physically able people using lifts even for one or two floors). Reshaping of healthcare provision e.g. moving sites from hospitals into the community provides an opportunity for 'designing in' active travel from the outset. Improvements to physical infrastructure in support of walking and cycling can be made to existing sites on an ongoing basis and opportunistically. Some measures to improve the physical environment for walking and cycling to NHS sites are relatively low-cost and concerned with the detail of design, for example: well designed and located cycle parking (with the introduction of additional cycle parking in line with growth in demand). A wide range of environmental measures can support existing pedestrians and cyclists and encourage more people to walk or cycle e.g. 'filtered permeability' of surrounding streets to favour walking and cycling over motorised access, 20mph speed limits to reduce road	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			NICE Guidance on physical activity and the environment (PH8), on physical activity in the workplace (PH13), and on walking and cycling (PH41) emphasise that barriers to walking and cycling need to be addressed to make it easier for people to be active in their daily lives. This requires liaison with authorities responsible for the built and natural environment such as planners, transport authorities, building managers, designers and architcts. NICE guidance PH8 recommends prioritising pedestrians, cyclists and users	danger presented to people on foot or bicycle; attractive and 'inviting' pedestrian and cycling routes to and through NHS sites; well located bus stops with realtime information about services; crossing points located on pedestrian 'desire lines' with crossings (where signalised) that do not cause pedestrians undue delay in their journeys.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads (this includes people whose mobiity is impaired) as well as ensuring new workplaces are linked to walking and cycling networks.		
003	SCM1	*Key area for quality improvement 2* Active travel access by staff, patients and visitors to NHS as the norm, via '**soft measures**' including active management of travel demand at NHS sites	There is good evidence that 'active travel' modes (walking and cycling) alone or in conjunction with public transport are an effective way to build physical activity into people's lives, helping them to meet CMO guidance on levels of physical activity.	Continued low mode share of walking and cycling for short trips in England, and high proportion of short trips undertaken by private car, means that opportunity for many people to integrate physical activity into their daily routine is not taken up. Insufficiently high levels of physical activity amongst all age groups has a range of consequences for the NHS and wider society including effects on workforce health - and more generally on prevalence of non-communicable diseases.	DfT local area walking and cycling statistics for England and Wales, most recently published at https://www.gov.uk/government/publications/local-area-walking-and-cycling-in-england-2011-12 highlights low levels (and essentially static levels) of cycling across England e.g. this notes that, according to the 2011 Census, around 2% of adults in England usually travel to work by bicycle.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			Walking and cycling are low-cost modes of transport, ideal for relatively short trips and are widely available to people of all ages. NHS sites are major 'trip generators' with – taking London as an example – Transport for London's Health Action Plan estimating that around 5% of trips (1 million per day) in London are related to the healthcare sector. This report also notes that "Travel and accessibiity are of great importance to the public, patients and staff, particularly when changes to healthcare	Current levels of car dependence have other associated costs, some of which have been quantified, under headings of collisions, traffic congestion; air pollution; carbon emissions; community severance; operating costs; and, in the context of NHS sites, pressure on NHS property (some NHS sites have high proportions of land given to car parking). There is widespread dissatisfaction within the sustainable transport campaigning community in the UK with cycling and walking infrastructure and the level of priority given to cyclists and pedestrians in designing and maintaining physical infrastructure and in ensuring that it remains accessible for its intended users. Improvements in physical infrastructure in support of walking and cycling need to go hand in hand with awareness raising and promotional activities such as those set out in NICE Walking and Cycling guidance PH41. Ongoing monitoring and management of infrastructure is needed to maximise health benefits	There has been an overall decline in average distances walked since 1995/97, see Department for Transport National Travel Survey statistics, Table NTS0305 Average distance travelled by mode: Great Britain, 1995/97 to 2012 https://www.gov.uk/government/statistical-data-sets/nts03-modal-comparisons See also: 'Improving the health of Londoners: transport action plan'. Transport for London, February 2014. p. 56 of this document refers to the authors' Health Service Travel Analysis Toolkit (HSTAT), also 'Transport Planning for Healthier Lifestyles' and 'Transport Planning for Health'.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			provision are being discussed." (p. 56) NICE Walking and Cycling guidance (PH41) identifies the importance of 'soft measures' [complementary to measures relating to physical infrastructure] as part of an overarching strategy in the workplace (including NICE workplaces) to promote walking and cycling in and around the workplace. Measures cited included to identify an 'active travel champion' (or champions) in the workplace, at a sufficiently senior level, whose role included a number of practical	by continuing to support active travel, and encouraging further uptake of active travel. NHS sites need to have a well developed understanding of how people travel to the site and a strategy to increase active travel uptake, with ongoing monitoring and updating as needed. As part of this, it is important to listen to the views of existing and would-be pedestrians, cyclists and users of public transport in order to understand and be able to quickly address local barriers to active travel. Barriers to active travel in the vicinity of NHS settings may include driver behaviour and this needs to be addressed in liaison with local police (see comments regarding community safety and road danger reduction in NICE Walking and Cycling guidance, PH41, recommendations 2, 3, 8). Many measures to improve quality of the experience of cycling and walking to NHS sites are to do with changing attitudes and behaviour, and not necessarily high-cost.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			activities to encourage and facilitate walking and cycling by staff and others visiting the workplace. This guidance also emphasises the need to ensure workplace programmes are developed using an evidence-based theoretical model of behaviour change and the provision of promotional material tailored to the specific workplace.		
004	Rotherham Doncaster & South Humber NHS Trust	Key area for quality improvement 1	Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, and our work and to	Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults. People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general	No health without Mental Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			achieving our potential.	population.	
005	Rotherham Doncaster & South Humber NHS Trust	Key area for quality improvement 2	The growing problem of obesity in a very hands-on, positive way, by instilling healthy eating and exercise habits into people from a young age	Major conditions such as cardiovascular disease, chronic lung disease, some cancers and type 2 diabetes are linked to people's lifestyles and behaviours	NICE – PH6 Behaviour Change: the principles for effective interventions Change for Life https://www.weightlossresources.co.uk/healthy_eating/healthy-lifestyle/change-for-life.htm
006	Rotherham Doncaster & South Humber NHS Trust	Key area for quality improvement 3	Millions of people come into contact with the NHS every day, and we believe that every contact must count as an opportunity to maintain and, where possible, improve their mental and physical health and wellbeing.	Every healthcare professional should "make every contact count": use every contact with an individual to maintain or improve their mental and physical health and wellbeing where possible, in particular targeting the four main lifestyle risk factors: diet, physical activity, alcohol and tobacco – whatever their specialty or the purpose of the contact.	The NHS Role in the Public's Health: A Report from the NHS Future Forum https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216423/dh_132114.pdf
007	Royal College of Paediatrics and Child Health	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the Physical Activity topic engagement exercise. We have not received any responses for this consultation.			
008	RCN	This is to inform you that there are no comments to submit to inform on the above topic engagement exercise at this time. Thank you for the opportunity, we look forward to participating in the next stage of the process.			

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
009	Macmillan cancer support	Brief interventions to enable people to choose to become and stay more active. This needs to be integrated into primary and secondary care pathways for the primary prevention and management of all clinical conditions where physical activity is a modifiable risk factor eg. all cancers, CVD, type 2 diabetes	There is excellent evidence that physical activity is a modifiable risk factor for over 20 health conditions. This isnot just primary prevention, but also to help people to live as well as possible for as long as possible eg. Being active during and after cancer can have a significant impact on clinical outcomes. However the evidence demonstrates that in order to maximise the opportunity physical activity has to offer, people have to be enabled and supported to choose to make a this lifestyle change in the long	Currently Health Care Professionals are generally not , confident, motivated or skilled to raise the issue of inactivity, assess need and deliver a brief intervention to enable people to become and stay more active for the prevention and management of long term conditions. Developing skills and competency training for health and allied health care professionals will ensure they have the knowledge of the benefits of physical activity in improving health and wellbeing outcomes for both the prevention and management of long term conditions. In addition to the ability and confidence to identify people who would benefit from being more active, health professionals should be confident to raise the issue of physical activity, discuss the benefits in a **person centred, shared decision making style**, then support people to choose to become more active, signposting to further	Insight research by Macmillan Cancer Support shows that health care professionals are not confident in raising the issue, may not even understand its relevance as a clinical treatment. Shared decision making skills, behaviour change competencies and knowledge of the benefits of physical activity are not included to an appropriate degree within undergraduate medical training programmes. Physical activity has just had its QOF points removed for hypertension. There is very limited inclusion of physical activity in NICE clinical guidance, despite the evidence eg living with and beyond cancer, where it has been introduced eg NICE prostate cancer guidance it refers only to 12 week exercise programmes rather than drawing on the broader NICE PH guidance on

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			term. A traditional prescribing style is ineffective except for the most motivated people, and has the potential to increase inequalities. This is important as it applies to all long term condition specific rehabilitation schemes, exercise on referral and walking groups. No physical activity scheme whether prevention or rehab should be considered except in the context of a high quality person centred behaviour change intervention.	information and support. Currently there is not a wide spread of physical activity care pathway services (**Let's Get Moving, DH 2009; NICE PH2, 6, 44, 49)** that are well integrated into care. Ensuring this happens will improve support for HSCPs and also provide consistent opportunities for people to become active. It is also important to ensure they are developed systematically by local decision makers and with good governance to ensure a high quality service and patient experience. Seamless service delivery between health care (secondary and primary) and the community leisure service offer (including walking groups, exercise on referral for long term conditions and other opportunities based on patient choice) is also essential and finally it is crucial that the pathway is well monitored and evaluated (**NICE PH41, PH2 – exercise on referral in process of update**). This will improve future learning and development of	physical activity to enable sustainable behaviour change. **Supported by MCS insight research (journal article pending publication)** **Supported by MCS evidence reviews** http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/ConciseEvidenceReview.pdf http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/PhysicalActivityEvidenceBasedGuidance.pdf **Macmillan Cancer Support marketing insight report** (http://www.macmillan.org.uk/Documents/AboutUs/Health_professionals/Physicalactivity/Marketing-activity-to-cancer-survivors.pdf) **Towards an understanding of**

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				physical activity opportunities and support for people with health conditions.It is also important that the community leisure offer available is of a high quality and adheres to existing NICE guidance and other best practice (**NICE PH41, PH2 – exercise on referral in process of update**) including social marketing insight by Sport England and DH that enables decision makers to understand the barriers and motivators to enabling the adult population in England become and stay more active. It is paramount that high quality, evidence based services are implemented to ensure people living with health conditions are supported to become more active to live as well as possible for as long as possible.	**what challenges cancer health professionals face in raising lifestyle issues with patients, and pointers for the development of an intervention framework to support practice change**. **Macmillan Cancer Support and Coventry University (2013). Not yet published but paper can be supplied.** **NICE PH2, 6, 44, 49** **Let's Get Moving, DH, 2009 & 2012** Macmillan Cancer Support is working with local decision makers across the UK to develop this integrated care pathway approach, it is working well, however without intervention the default reaction is to just link to exercise on referral and use a non patient centred telling style to tell

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					patients to go there, resulting in poor take up and low longer term behaviour change. We have unpublished evaluations on existing physical activity services that can be shared.
010	Macmillan cancer support	Physical Activity services for people living with and beyond cancer	As well as the considerable evidence outlining the preventative effect of physical activity for cancer there is also an increasing evidence base for the benefits of physical activity for people living with and beyond cancer. Physical activity can help prevent and manage some of the consequences of treatment, including fatigue,	Existing knowledge and awareness amongst health and social care professionals is very limited, with some still believing that 'rest is best'. This is meaning people living with and beyond cancer are not being offered any support to become active during or after their treatment, even though they may be actively asking for it. Through our insight work we know that individuals trust their health professionals and therefore these professionals are in a perfect position to recommend physical activity and in doing so patients will be more likely to consider it as they will know it is safe.	The American Centre for Sport Medicine and British Association for Sport and Exercise Sciences both released evidence in 2010 stating that physical activity for people living with and beyond cancer was safe and people should build up to the recommended physical activity guidelines. **Macmillan Evidence reviews (see above)** **Macmillan Cancer Support marketing insight report (see above)**

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			depression, bone thinning, muscle wasting, blood clots, erectile dysfunction, heart damage. Emerging evidence has also shown that it may help reduce the relative risk of recurrence for some cancers and disease progression for others. Physical activity also help reduce social isolation and enable people who want to, to be able to return to work. Despite the considerable benefits we know that health and social care professionals' awareness of the benefits of physical activity for people living with and		

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			beyond cancer are limited.		
011	SCM2	CCG's to include physical activity within all relevant clinical pathways (diabetes, Stroke, Coronary Heart Disease, Mental Health, Osteoarthritis, hypertension).	Clear benefits to embedding PA within these pathways, both as primary prevention and to support treatment/secondary prevention.	Extent to which this is included locally currently is mixed.	NICE Pathway – Encouraging physical activity to prevent or treat specific conditions (obesity, mental health, cardiovascular disease, weight management and pregnancy) NICE CG177 Exercise as treatment for Osteoarthritis NICE CG34 Hypertension. Lifestyle interventions NICE CG 15 Type 1 diabetes Start Active Stay Active (CMO report 2011) "*Regular physical activity can reduce the risk of many chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions.*" *"Physical inactivity is the fourth leading risk factor for global mortality (accounting for 6% of*

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					deaths globally)." *Table 1 Relationship between physical activity and health outcomes*
012	SCM2	GP Referrals for physical activity	GP consultations with patients present teachable moments. Referrals for exercise can be appropriate alternative to medication in some cases.	Local interrogation of the GP referral process has identified that 'small frictions' in the referral process can cause lower referral rates than would be expected. Work to make it easier for GP's to complete referral forms, have shown some improvement in referral rates. There is a need to mainstream this approach.	No additional information provided by stakeholder.
013	SCM2	Motivational interviewing: All opportunities for brief interventions promoting physical activity should be taken in NHS settings.	NHS settings and professionals present an relevant and authoritative messenger for physical activity promotion.	Local perception that the opportunity of brief interventions in primary care in particular is not being effectively exploited.	http://guidance.nice.org.uk/PH41 replaced PH2 (brief interventions) but it may be that this lost some currency (or relevance) within primary care
014	SCM2	NHS settings as beacons of good practice. Built environment that	Good evidence on the benefit of environment on	Significant current change in NHS estates in relation to financial pressures, may be an opportunity to embed best practice in built form,	NICE PH13

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		promotes physical activity, staff workplace health, etc.	physical activity.	including optimising use of estate through consolidation enabled by lower parking levels etc.	
015	SCM2	Effective travel plans should be in place covering all staff, patient and carer travel to NHS premises, including primary care.	NHS to show best practice in promoting active travel to staff and patients (where appropriate)	Currently very mixed in terms of application of travel planning by different trusts, plus confusion of what should be required.	Some (now dated) good practice from London NHS Travel Network http://www.tfw.org.uk/documents/nhs-travel-plan-guide-part-1.pdf and a recent NHS cycling strategy **http://tinyurl.com/qh8o4cy** Health Development agency: http://www.nice.org.uk/niceMedia/documents/improving_patient_access.pdf
016	SCM	Exploring the role of and efficacy of (often commissioned) structured fitness sessions in controlled	Potential large gains through development of habitual active behaviour over time consuming 'add-on' activities	Move of public health to local authorities may raise profile of such measures (given wider, non-health benefits of modal shift)	None known.

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		environments vs promotion of activities that can be embedded in everyday routine such as walking/cycling to work	to the daily routine		
017	SCM2	Exploring promotion of active travel to children and parents through home visitors, school nurses etc.	Ensuring such staff are knowledgeable about cycling/walking opportunities and enthusiastic proponents may help increase impact of partnership programmes with local authority transport teams	Currently largely undeveloped.	None known.
018	Royal College of Physicians (RCP)	The RCP is grateful for the opportunity to comment on the above engagement exercise. In doing so, we have liaised with our experts on the RCP Sport and Exercise Medicine who have returned the following comment: 1. Each NHS organisation, including Trusts and CCGs, should have a clear physical activity strategy to promote regular physical activity for their staff. There should be a Physical Activity Lead responsible for this in each organisation. There should also be protected funding to develop the strategy. This could be used for the development of the environment at work to encourage regular exercise. This could include exercise classes, walking and running clubs, provision of storage for cycles, changing rooms and showers for staff members			

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		2. Health benefits of physical activity should be taught formally to all undergraduates doing Medicine, Nursing and Physiotherapy. 3. Each CCG should have a Physical Activity Coordinator who is responsible for ensuring that each General Practice is keeping data on the physical activity levels of their patients. All patients attending GP surgeries should have their level of physical activity monitored at least once every 3 years, ideally once a year. They should also be responsible for developing a physical activity strategy including clinical pathways to enable patients to receive advice on performing regular exercise (see below). 4. Each of the Medical Royal Colleges should have strategies in place for disseminating information to their members on the health benefits of exercise and how this relates to each specialty. 5. Exercise professionals at Level 4 should be regulated by the Health Care Professions Council. Exercise professionals can play an important role in promoting exercise and especially in supervising exercise programmes for people in general and also for patients. In order for them to work with patient populations they need to be highly skilled and this is set at a level 4 qualification. The current problem is that this organisation is self-regulated. To provide transparency and to give Doctors confidence that they can safely refer their patients for exercise, level 4 exercise professionals need to have the same level of regulation as physiotherapists, ie be regulated by the HCPC.			